ANNUAL UTILIZATION REPORT OF LONG-TERM CARE FACILITIES - 2007

1. Facility DBA (Doing Business As) Name:			2. OSHPD Facility No.:
3. Street Address:	4. City:		5. Zip Code:
6. Facility Phone No.: ( )	7. Administrator Name:		8. Administrator's E-Mail Address:
9. Was this facility in operation at any time during the year? Yes ☐ No ☐	Dates of Operation (MMDDYYYY): 10. From:	11. Through:	
12. Name of Parent Corporation:			
13. Corporate Business Address:	14. City:	15. State	16. Zip Code:
17. Person Completing Report	18. Phone No. ( ) Ext.		
19. Fax No. ( )	20. E-mail Address:		

CERTIFICATION

I declare the following under penalty of perjury: that I am the current administrator of this health facility, duly authorized by the governing body to act in an executive capacity; that I am familiar with the record keeping systems of this facility; that the records and logs are true and correct to the best of my knowledge and belief; that I have read this annual report and am thoroughly familiar with its contents; and that its contents represent an accurate and complete summarization from medical records and logs of the information requested.

Date

Administrator Signature

Administrator Name (Please Print)

Completion of the Annual Utilization Report of Long-term Care Facilities is required by Section 127285 of the Health and Safety Code, and is a requirement for the licensure of your health facility pursuant to Section 70735 and 71533 of Title 22 of the California Code of Regulations. Failure to complete and file this report by February 15 may result in action against the facility's license.

Office of Statewide Health Planning and Development
Healthcare Information Division
Accounting and Reporting Systems Section
Licensed Services Data Unit
400 R Street, Suite 250
Sacramento, CA 95811
Phone: (916) 326-3854
FAX: (916) 322-1442

Section 2

OSHPD FACILITY ID No. _____

LICENSE CATEGORY (Completed by OSHPD)

Line No.		(1)
1	Skilled Nursing Facility	
	Intermediate Care Facility	
	Intermediate Care Facility/ Developmentally Disabled	
	Congregate Living Health Facility	

LICENSEE TYPE OF CONTROL

Line No.		(1)
5	From the list below, select the ONE category that best describes the licensee type of control of your long-term care facility, i.e. the type of organization that owns the license. (There will be a drop down box in ALIRTS - see list of choices below.)	

LICENSEE TYPE OF CONTROL CHOICES

1	City and/or County
2	District
3	Non-profit Corporation (incl. Church-related)
4	University of California
5	State

6	Investor - Individual
7	Investor - Partnership
8	Investor - Limited Liability Company
9	Investor - Corporation

FACILITY CERTIFICATIONS

From the certification categories below, check those categories for which your facility was certified or contracted during the year. (Check all that apply.)

Line No.		(1)
21	Medicare Skilled Nursing	
22	Medi-Cal Skilled Nursing	
23	Medi-Cal Skilled Nursing/Mentally Disordered (Special Treatment Program)	
24	Medi-Cal Intermediate Care (General)	
25	Medi-Cal Intermediate Care/Developmentally Disabled	
26	Medi-Cal Subacute or Subacute - Pediatric	

Section 3

OSHPD FACILITY ID No. _____

CENSUS and PATIENT DAYS

For each licensed bed category (columns 1 through 5), enter prior year ending census (line 1), admissions (line 2), discharges (line 3), current year ending census, and patient days (line 5).

Line No.		(1) Skilled Nursing	(2) Skilled Nursing Mentally Disordered	(3) Intermediate Care	(4) Intermediate Care Developmentally Disabled	(5) Congregate Living Health Facility	(6) Total
1	Dec. 31, 2006 Census						
2	+ Admissions						
3	- Discharges						
4	Dec. 31, 2007 Census (Total)						
5	Patient Days for 2007						
7	Licensed Beds						
8	Licensed Bed Days						

PATIENTS ADMITTED FROM and DISCHARGED TO

LTC Patients admitted from and discharged to each place shown.

Line No.		(1) Admitted From	(2) Discharged To
11	Home		
12	Hospital		
13	State Hospital		
14	Other LTC		
15	Residential Board & Care *		
16	Other		
17	AWOL		
18	Death		
20	Total		

* Include RCFE, ARF, OTHER Assisted Living Facilities, or a secured facility such as an Alzheimer's unit, jail or prison.

PATIENTS BY PAYMENT SOURCE ON DECEMBER 31

Number of patients in the facility on December 31, whose principal source of payment was from the sources shown.

Line No.		(1) Patients
21	Medicare	
22	Medi-Cal	
23	Managed Care*	
24	Private Insurance	
25	Self-Pay	
29	All Other	
30	Total	

* Include patients enrolled in Medicare and Medi-Cal managed care health plans.

Section 3 (con't)

OSHPD FACILITY ID No. _____

DISCHARGES by LENGTH OF STAY

Number of discharges for each of the ranges of length of stay below.

Line No.	Time in Facility	(1) Patients
31	Less than 2 weeks	
32	2 weeks to less than 1 month	
33	1 month to less than 3 months	
34	3 months to less than 7 months	
35	7 months to less than 1 year	
36	1 year to less than 2 years	
37	2 years to less than 3 years	
38	3 years to less than 5 years	
39	5 years to less than 7 years	
40	7 years to less than 10 years	
41	10 years or longer	
45	Total	

HOSPICE PROGRAM

Line No.		(1)
51	Did your facility offer a hospice program during the report period?	Yes ☐ No ☐

SPECIAL PROGRAMS

Line No.		(1) Patients
52	Number of patients diagnosed as having AIDS, ARC, prodromal AIDS or HIV-related diseases and illness (HTLV-III / LAV).	

Line No.		(1)
53	Does your facility offer a specialized program for Alzheimer's patients?	Yes ☐ No ☐

Line No.		(1) Patients
54	Number of patients who had a primary or secondary diagnosis of Alzheimer's Disease.	

Section 4

OSHPD FACILITY ID No. _____

MALES - RACE AND AGE OF MALE LTC PATIENTS ON DECEMBER 31

Line No.	Race	(1) < 45	(2) 45-54	(3) 55-64	(4) 65-74	(5) 75-84	(6) 85-94	(7) 95 +	(8) Total
1	White								
2	Black								
3	Asian / Pac. Islander								
4	Native American								
5	Other / Unknown								
6	Total Males								

FEMALES - RACE AND AGE OF FEMALE LTC PATIENTS ON DECEMBER 31

Line No.	Race	(1) < 45	(2) 45-54	(3) 55-64	(4) 65-74	(5) 75-84	(6) 85-94	(7) 95 +	(8) Total
11	White								
12	Black								
13	Asian / Pac. Islander								
14	Native American								
15	Other / Unknown								
16	Total Female								

ETHNICITY OF PATIENTS ON DECEMBER 31

Line No.		(1) Male*	(2) Female**	(3) Total
21	Hispanic			
22	Non-Hispanic			
23	Unknown			
25	Total Patients			

* Total male patients in column 1, line 25 must be the same as reported in column 8, line 6.

** Total female patients in column 2, line 25 must be the same as reported in column 8, line 16.

Section 5

OSHPD FACILITY ID No. _____

Section 127285 (3) of the Health and Safety Code requires each facility to report "acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars ($500,000)."

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT DURING THE REPORT PERIOD

Line No.		(1)
1	Did your facility acquire any diagnostic or therapeutic equipment that had a value in excess of $500,000? (If 'Yes', fill out lines 2 through 11, as necessary, below.)	Yes ☐ No ☐

DIAGNOSTIC AND THERAPEUTIC EQUIPMENT DETAIL

Line No.	(1) Description of Equipment	(2) Value	(3) Date of Acquisition (MMDDYYYY)	(4) Means of Acquisition (Check one.)			
2				Purchase ☐	Lease ☐	Donation ☐	Other ☐
3				Purchase ☐	Lease ☐	Donation ☐	Other ☐
4				Purchase ☐	Lease ☐	Donation ☐	Other ☐
5				Purchase ☐	Lease ☐	Donation ☐	Other ☐
6				Purchase ☐	Lease ☐	Donation ☐	Other ☐
7				Purchase ☐	Lease ☐	Donation ☐	Other ☐
8				Purchase ☐	Lease ☐	Donation ☐	Other ☐
9				Purchase ☐	Lease ☐	Donation ☐	Other ☐
10				Purchase ☐	Lease ☐	Donation ☐	Other ☐
11				Purchase ☐	Lease ☐	Donation ☐	Other ☐

BUILDING PROJECTS COMMENCED DURING REPORT PERIOD COSTING OVER $1,000,000

Section 127285 (4) of the Health and Safety Code requires each facility to report the "commencement of projects during the reporting period that require a capital expenditure for the facility or clinic in excess of one million dollars ($1,000,000)."

Line No.		(1)
25	Did your facility commence any building projects during the report period which will require an aggregate capital expenditure exceeding $1,000,000? (If 'Yes', fill out lines 26 through 30, as necessary, below.)	Yes ☐ No ☐

DETAIL OF CAPITAL EXPENDITURES

Line No.	(1) Description of Project	(2) Projected Total Capital Expenditure	(3) OSHPD Project No. (if applicable)
26			
27			
28			
29			
30			